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56384 JUN 12 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

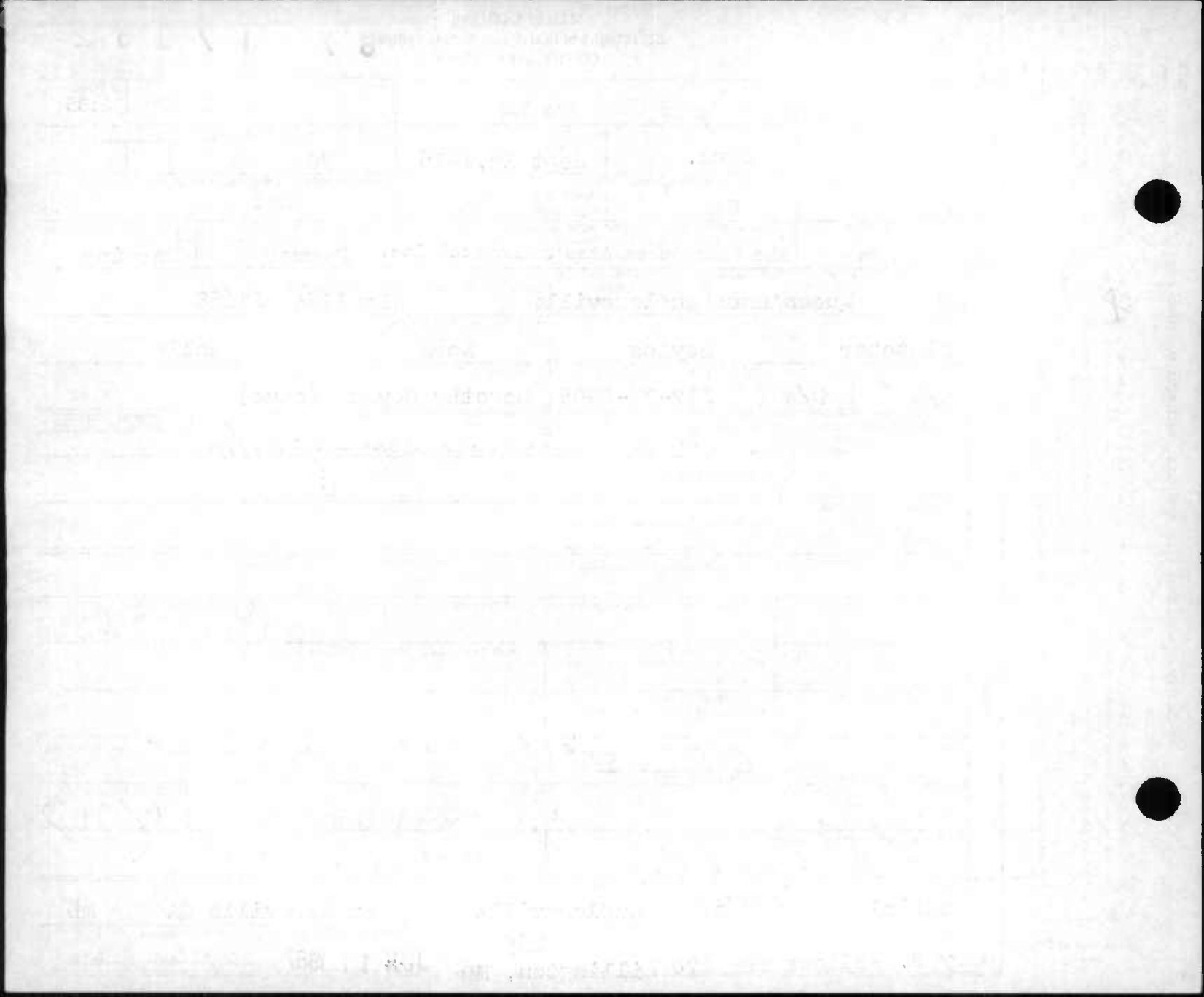
1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 7 5 6 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albert James Boyles			2a. DATE OF DEATH MONTH DAY YEAR 6- 3- 87			2b. HOUR A 4:35 M	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Sept 16, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	
						12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY Queen Annes		13c. CITY OR TOWN Sudlersville	
				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Box 115A 21668	
14. FATHER'S NAME FIRST MIDDLE LAST Fletcher Boyles				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Walls			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Dorothy Boyles (same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma of colon</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>6/2</i> , 19 <i>87</i> , to <i>6/3</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>6/3</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Michael P. Bey</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6/5/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael P. Bey</i>				22e. ADDRESS <i>Millington Md</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <i>6/5/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sudlersville</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Sudlersville QA MD</i>	
24. FUNERAL DIRECTOR NAME Gary B. Fellows Box 270 Millington, MD				ADDRESS 21651		25a. DATE REC'D. BY REGISTRAR <i>JUN 11 1987</i>	
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

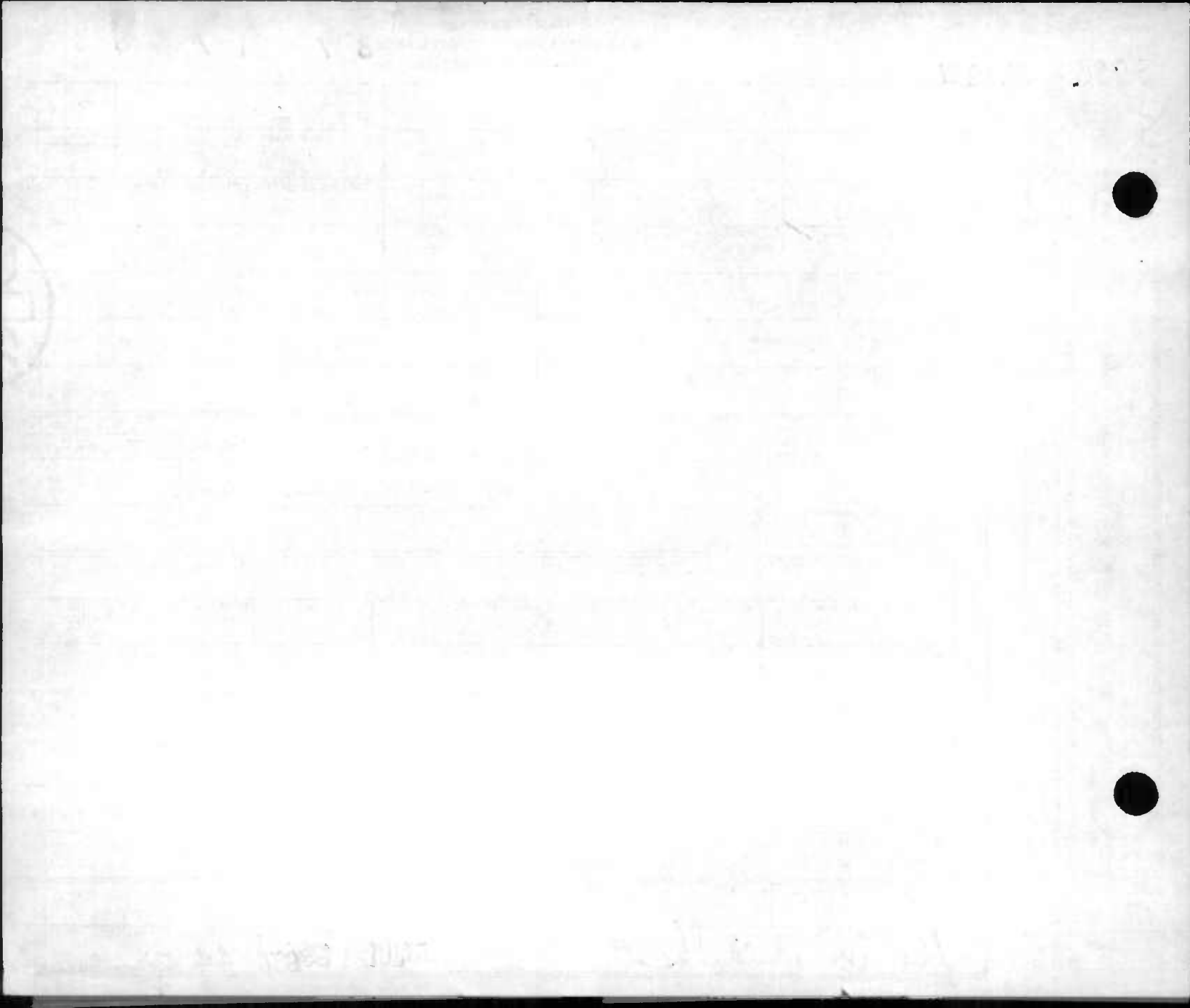
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 1 7 5 6 3

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR		MIN.	
RUTH ELIZABETH HARPER								JUNE 20 1987								?		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		MONTHS		DAYS		HOURS		MIN.	
Female		White		April 17, 1903		84													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
New York City		USA				Kent Co													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Chestertown		At Home RFD Quaker Neck		Housewife															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE											
Maryland		Kent		Chestertown				RFD Quaker Neck										21620	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT											
Charles M. Hall		Ella Louise True (Trew)				110 12 5125 A		Deceased while living											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				Arteriosclerotic Cardiovascular Disease		Probable Myocardial Infarction				7 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from Feb 24, 19 85, to June 23, 19 87, that (I) we) lost saw the deceased alive on Nov 29, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED											
Susan K. Ross								6/24/87											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Susan K. Ross		Chestertown, Md. 21620		Burial		June 26, 1987		Arlington National Cemetery		Arlington, Va.									
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
J. Willis Wells		JUL 1 1987		Julia Davidson-Pudney															



056054 JUN

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 7 5 6 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Willie Brewer Howe			2a. DATE OF DEATH MONTH DAY YEAR June 4 1987		2b. HOUR A. M. 8:20
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR December 8, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	
14. FATHER'S NAME FIRST MIDDLE LAST James Moss			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Brewer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> IF YES, GIVE WAR OR DATES no		16b. SOCIAL SECURITY NO. 197 34 4677		17. INFORMANT Rosemary Wetherill	
			ADDRESS P.O. Bx # 12 Chestertown., Md. 21620		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>gastrointestinal bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>M. Bienefeld</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6/4/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Bienefeld M. D.		22e. ADDRESS Chestertown, Md. 21620	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 6/5/87	23c. NAME OF CEMETERY OR CREMATORY MacNabb Crematory	23d. LOCATION CITY OR TOWN Baltimore, Md. Catonsville
24. FUNERAL DIRECTOR NAME <i>J. Willis Wells</i>		25. DATE REC'D. BY REGISTRAR JUN 05 1987	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



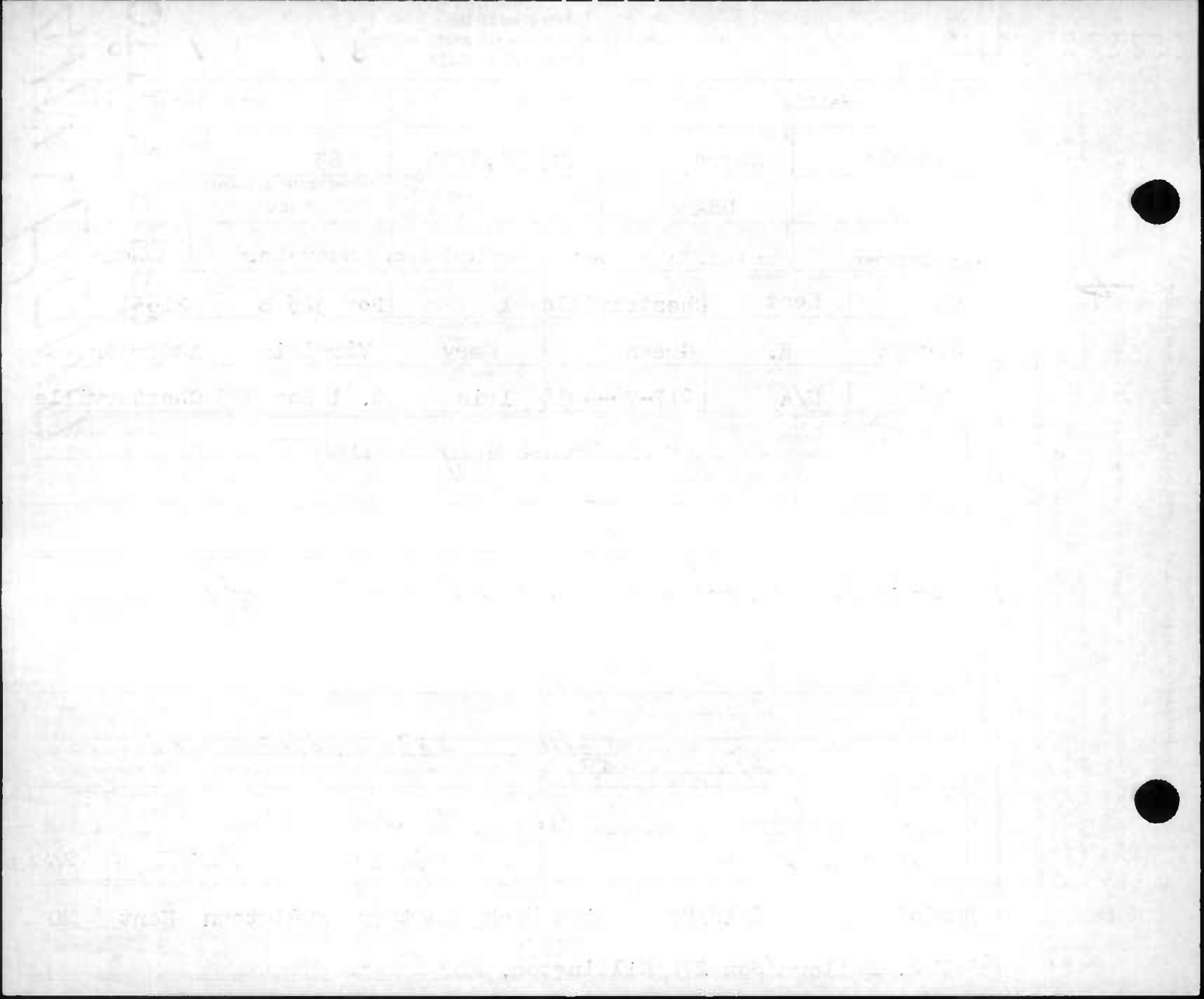
1822 JUL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8717565	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hattie Mae Greene						2a. DATE OF DEATH MONTH DAY YEAR 6-12-87			2b. HOUR A 3:28 A		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Aug 31, 1923		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 63		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD					
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY home			
13a. STATE MD						13b. COUNTY Kent		13c. CITY OR TOWN Chesterville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph E. Green						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Virginia Anderson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Iris		ADDRESS Rt. 1 Box 325 Chesterville					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>① Shock ② Adenocarcinoma of R lung, terminal.</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/11</u> , 19 <u>87</u> , to <u>6/12</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>6/11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>K.H. Wun</u> DEGREE <u>MD.</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIN KUE WUN						22e. ADDRESS 216 High Street, Chestertown, Md 20620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/18/87		23c. NAME OF CEMETERY OR CREMATORY Rich Neck Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Ewingtown Kent MD			
24. FUNERAL DIRECTOR NAME Gary B. Fellows						ADDRESS Box 270/Millington, MD		25a. DATE REC'D. BY REGISTRAR JUN 22 1987		25b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must file a notification of death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17566

REG. NO.

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	A	M
		MAGGIE CLARISSA JONES					June 16, 1987				8:15		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.					
Female	white	August 1, 1891		95		YRS.		MONTHS	DAYS	HOURS	MIN.		
9a. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland	USA				Kent		MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Chestertown	Magnolia Hall Nursing Center		Housewife										
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE								
Maryland		Kent	Chestertown	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	RFD Fairlee		21620						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
James A. French		Annie H. Venerable											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no		218 58 0561		Howard C. Jones (Jr.)		RFD Fairlee 21620 Chestertown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-20</u> 19 <u>84</u> to <u>6-16</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>6-12</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
<i>Robert W. Farr</i>						6/16/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Robert W. Farr M.D.		Chestertown, Md. 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		June 18, 1987		Saint Paul's Cem		near Chestertown, Md.							
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
<i>J. Willis Wells</i>		J. Willis Wells Chestertown, Md.		JUN 19 1987		<i>Julia Davidson-Randall</i>							

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EXHIBIT NO. 10700

NO. 10700



EXHIBIT NO. 10700

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01-2

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17561

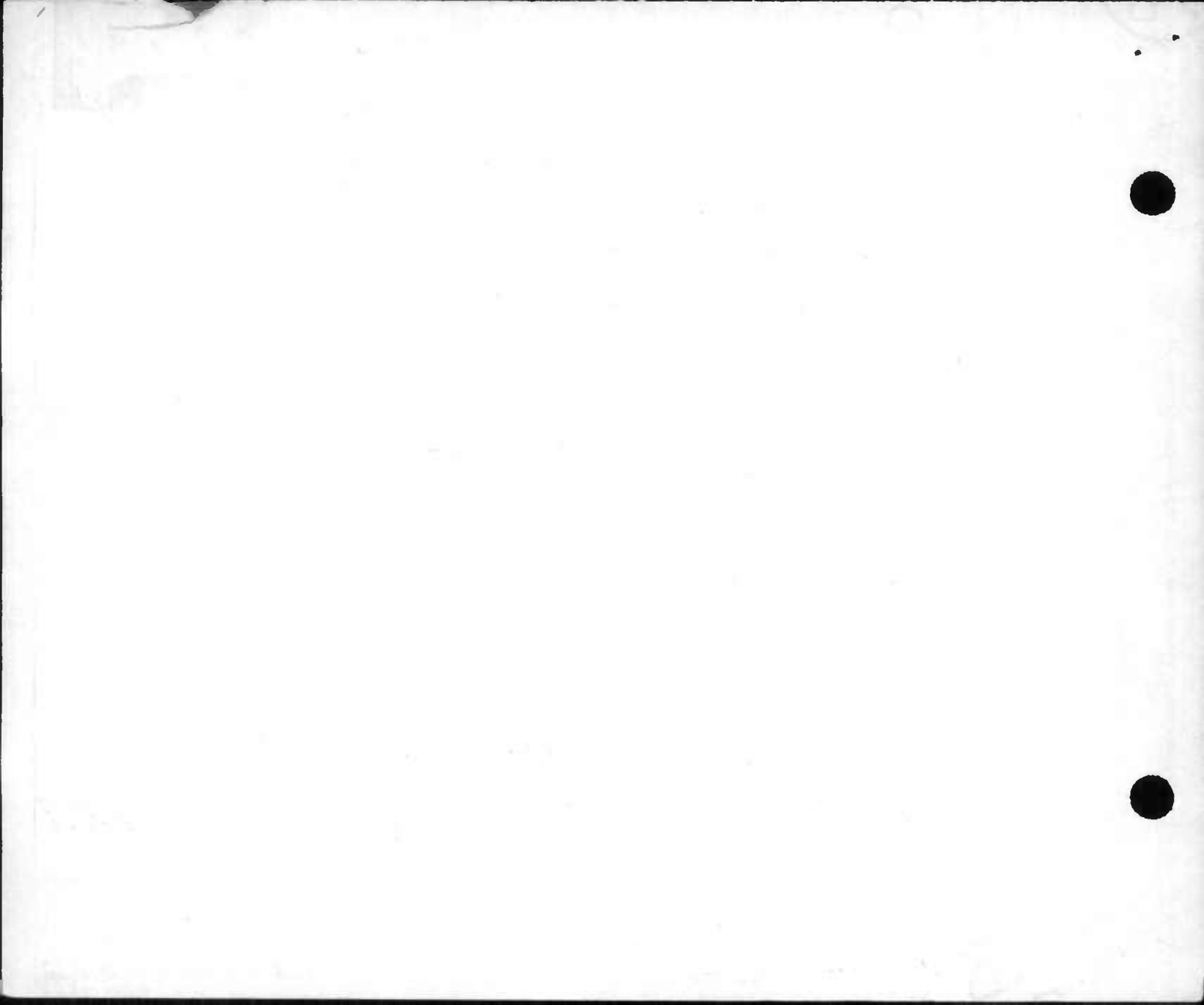
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SIMPERS MEDFORD JONES			2a. DATE OF DEATH MONTH DAY YEAR JUNE 28, 1987			2b. HOUR 12 P M	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10 31 1930		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Queen Anne Co		13c. CITY OR TOWN Chestertown	
14. FATHER'S NAME FIRST MIDDLE LAST Goldsborough (Goldie) Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Kendall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214 30 8472		17. INFORMANT RFD ADDRESS Mary Lou Jones Queen Anne Co Chestertown, Md. 21620			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Aspirin Regimen</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/24</u> 19 <u>87</u> , to <u>6/28</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>6/28</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I have) (did not) view the body after death.							
22b. SIGNATURE <u>Robert W. Farr</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/29/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr M.D.				22e. ADDRESS Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/30/1987		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.	
24. FUNERAL DIRECTOR NAME <u>J. Willis Wells</u>				J. Willis Wells ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUL 1 1987	
				25b. REGISTRAR'S SIGNATURE <u>Julia Seiden</u>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

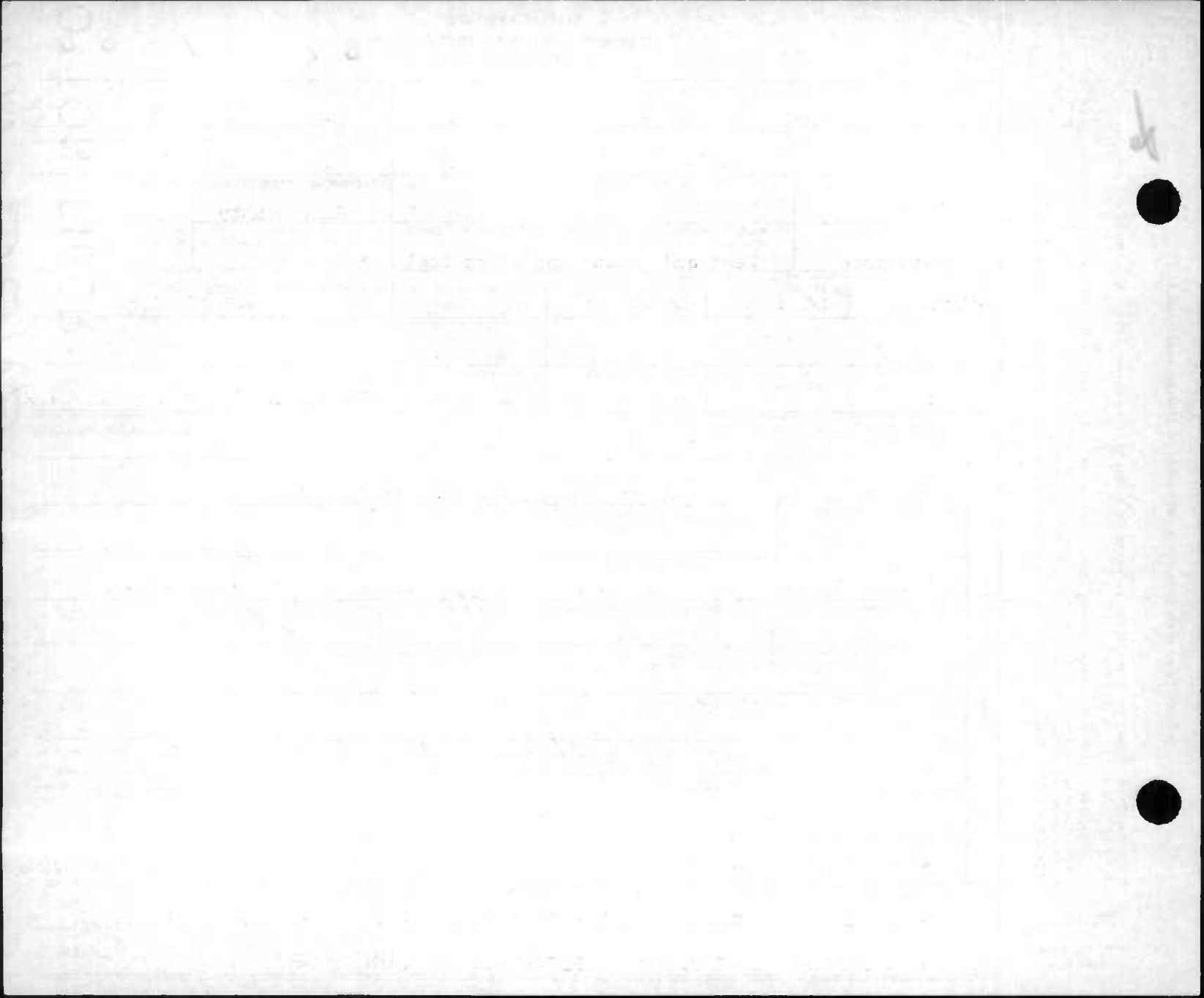


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or entombment.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DORIS ANN KNICKMAN					2a. DATE OF DEATH MONTH DAY YEAR June 25 1987		2b. HOUR 7:35 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 12 18		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY ---	
13a. STATE Maryland		13b. COUNTY baltimore		13c. CITY OR TOWN lansdowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 325 THIRD AVENUE 21227	
14. FATHER'S NAME FIRST MIDDLE LAST RUSSELL GEIGER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA ROBINSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-07-9761		17. INFORMANT ADDRESS HERBERT E. KNICKMAN, JR. 325 THIRD AVE. 21227					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>① Uncontrolled D.M. ② Old anterior Myocardial Infarction.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/13</u> 19 <u>87</u> to <u>6/25</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>6/25</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>K.H. Wun</u>				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIN KUE WUN				22e. ADDRESS 216 High Street, Chestertown, Md 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 6/26/87		23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS CREM.		23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE BALTIMORE MD.			
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				25a. DATE REC'D. BY REGISTRAR 21229 JUN 26 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 7 5 6 9

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CLARA DWYER KNIGHT			2a. DATE OF DEATH MONTH DAY YEAR June 16, 1987		2b. HOUR 3:15 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 29, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD.		
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 117 Elm St.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bank Teller		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John H. Dwyer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eunice K. Cooper			13e. STREET ADDRESS / ZIP CODE College Hgts 21620		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 10 0269		17. INFORMANT 117 Elm St. Helen K. Bryden Chestertown, Md. 21620				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma left lung with metastases</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> 19 <u>58</u> to <u>6/16/</u> 19 <u>87</u> . that (I) (we) last saw the deceased alive on <u>6-15</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Robert W. Farr</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/16/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr M.D.				22e. ADDRESS Chestertown, Md. 21620				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 19, 1987		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.		
24. FUNERAL DIRECTOR NAME <i>J. Willis Wells</i>				25a. DATE REC'D. BY REGISTRAR JUN 19 1987		25b. REGISTRAR'S SIGNATURE <i>Lia Twiss-Randall</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to make an autopsy.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 17570

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Henry Martinoli			2a. DATE OF DEATH MONTH DAY YEAR 6-29-87		2b. HOUR 11:57 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 31, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Annes CO. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled Veterans		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 118 Kinship Road 21222	
14. FATHER'S NAME FIRST MIDDLE LAST August Martinoli				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES) WW II 218-18-4593		17. INFORMANT ADDRESS Joseph Morisi 118 Kinship Road 21222					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Extensive antero-lateral myocardial infar.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>7 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-23</u> , 19 <u>87</u> , to <u>6-29</u> , 19 <u>87</u> , that (I) am lost saw the deceased alive on <u>6-29</u> , 19 <u>87</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was <u>did not</u> view the body after death.									
22b. SIGNATURE <u>h. J. J. J.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/30/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-2-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222				25a. DATE REC'D BY REG. NO. 87 JUL 02 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Randall</u>			

BP _____

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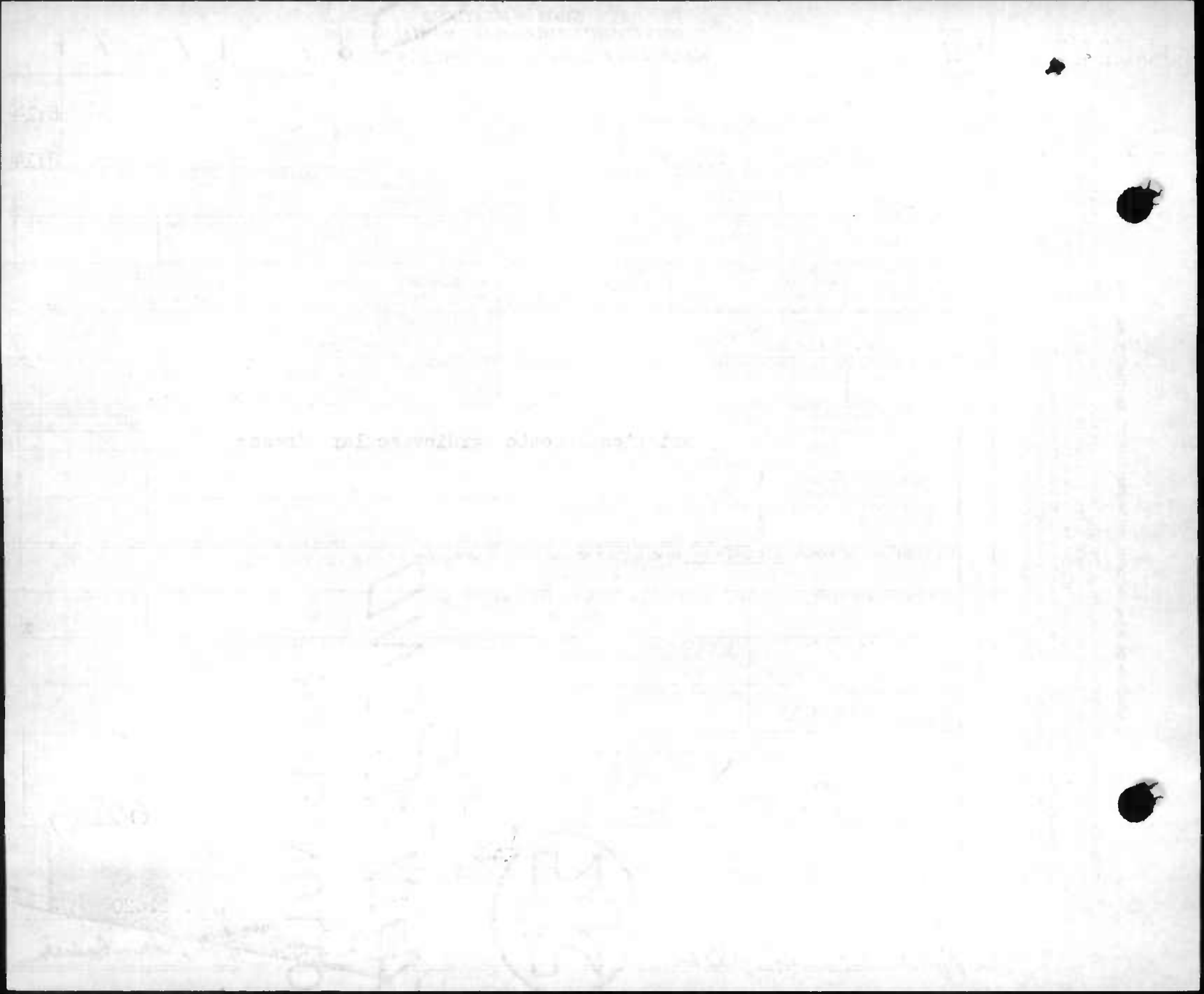
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 7 5 7 1	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELEANOR NEWTON						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6/19/ 1987		2b. HOUR 8:14			
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR May 30, 1912		6. AGE (IN YEARS) (LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR June 19, 1987 19		7d. HOUR 8:14		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co					
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS High St. 21620			
14. FATHER'S NAME FIRST MIDDLE LAST C. W. Wilson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Mogle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220 03 4464		17. INFORMANT Franklin Mench		17. ADDRESS 215 South Front St. Chestertown, Md. 21620					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Robert W. Farr</i>		M.D. <i>Deputy</i>		TITLE SPECIFY <i>Deputy</i>		MEDICAL EXAMINER		DATE SIGNED <i>6/22/87</i>			
EXAMINER'S NAME (TYPE OR PRINT)		Robert W. Farr		Kent County		Chestertown, Md. 21620		ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jun 23 1987		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md. 21620					
24. FUNERAL DIRECTOR NAME <i>J. Willis Wells</i>		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUL 1 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 7 5 7 2

REG. NO.

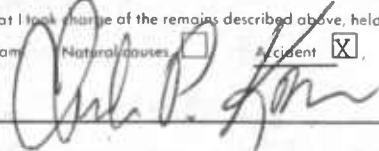

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jessie Elnora Powers		2a. DATE OF DEATH MONTH DAY YEAR 6 25 87		2b. HOUR 6:00 P	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 5, 1887	
6. AGE (IN YEARS LAST BIRTHDAY) 100 Yrs.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH KENT MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Annes Hospital, INC.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown	
14. FATHER'S NAME FIRST MIDDLE LAST John E. Matthews		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachael Faulkner		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. 214 18 4549		17. INFORMANT # 3 Superior St. John Blakeney Winsted, Conn. 06098			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/15/87</u> 19 <u>87</u> , to <u>6/25</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>6/15/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>C. Gottfried</u>		DEGREE M.D. C. GOTTFRIED PAULMAN M.D. MEDICAL BUILDING CHESTERTOWN, MD 21620		22c. DATE SIGNED 6/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			
23b. DATE 6/29/87		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.	
24. FUNERAL DIRECTOR NAME <u>J. Willis Wells</u>		25a. DATE REC'D. BY REGISTRAR JUL 1 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Swenson-Randall</u>	

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

058030 JUL

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

17573
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Sally		MIDDLE P.		LAST Richardson		2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 6-30 1987		7b. HOUR M 5:00P	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR March 5, 1933		6 AGE (IN YEARS) LAST BIRTHDAY 54 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-30 1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.					
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Para-legal		12b. KIND OF BUSINESS OR INDUSTRY Law			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE New Jersey		13b. COUNTY		13c. CITY OR TOWN Short Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Short Hill, N.J. 07078 1 Overbrook Terrace			
14. FATHER'S NAME FIRST MIDDLE LAST Charles V. Phelps				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred Hetzer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-30-2124		17. INFORMANT Maurice A. Richardson				ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8160 IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:05 PM 6-30 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto that lost control					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 301 Centerville, Queen Annes Co, MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Assistant				DATE SIGNED 7-1-87			
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 4, 1987		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland			
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212						ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR JUL 7 1987		25b. REGISTRAR'S SIGNATURE 	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 BP
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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

17574

1. DECEASED NAME (TYPE OR PRINT) Laura Virginia Goldsborough Rowe			2a. DATE OF DEATH MONTH DAY YEAR June 6, 1987			2b. HOUR M				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 26, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent				
10. CITY OR TOWN OF DEATH Golts		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, Box 21 (at home)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE MD			13b. COUNTY Kent		13c. CITY OR TOWN Golts		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 1, Box 21637	
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Goldsborough			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Elizabeth Hackett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Jacqueline Rowe (same)		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the colon								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years.		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Severe bronchiectasis.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the decedent) attended the deceased from May 1975 , 19____, to 6 June , 19 87 , that (I) (we) lost saw the deceased alive on 6 June , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.										
22b. SIGNATURE Wallace Obenshain, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7 June 87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wallace Obenshain M.D.						22e. ADDRESS Cecil-Kent Health services Cecilton, Md. 21913				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/13/87		23c. NAME OF CEMETERY OR CREMATORY John Wesley		23d. LOCATION CITY OR TOWN COUNTY STATE Sassafras Kent MD			
24. FUNERAL DIRECTOR NAME ADDRESS Gary B. Fellows Box 270 Millington, MD 21651						25a. DATE REC'D. BY REGISTRAR JUN 18 1987		25b. REGISTRAR'S SIGNATURE <i>John B. ...</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 1 7 5 7 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR	2b. HOUR		
Calvin Joseph Welch, Sr.				June 10, 1987			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		August 23, 1913		73 YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS	
Q.A. County		U.S.A.				Kent County		MD.	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13b. KIND OF BUSINESS OR INDUSTRY		14. RETIRED	
Chestertown		Kent-Queen Anne Hospital		Sate & Q.A.Co. Roads - Retired					
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		16. STATE		17. CITY OR TOWN		18. INSIDE CITY LIMITS?		19. STREET ADDRESS / ZIP CODE	
Maryland		Q.A.		Church Hill		YES <input type="checkbox"/> NO <input type="checkbox"/>		P. O. Box 21 21623	
20. FATHER'S NAME		21. MOTHER'S MAIDEN NAME		22. FIRST MIDDLE LAST		23. FIRST MIDDLE LAST		24. FIRST MIDDLE LAST	
Howard T. Welch		Hilda Bryant							
25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		26. SOCIAL SECURITY NO.		27. INFORMANT		28. ADDRESS		29. Church Hill, Calvin Welch, Jr., Rt. 2 Box 709, 21623	
No		215-16-3041							
30. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:		31. IMMEDIATE CAUSE (a)		32. DUE TO, OR AS A CONSEQUENCE OF		33. (b)		34. DUE TO, OR AS A CONSEQUENCE OF	
Circulatory Collapse									
35. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST		36. (b)		37. (c)		38. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		39. several minutes	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
40. DATE OF OPERATION		41. CONDITION FOR WHICH OPERATION WAS PERFORMED		42. AUTOPSY?		43. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		44. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
45. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		46. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		47. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		48. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		49. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
49. INJURY OCCURRED		50. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		51. LOCATION STREET CITY OR TOWN COUNTY STATE		52. WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		53. 22a. I certify that (I) (this hospital) attended the deceased from 5/19/87 to June 19/87, that (I) (we) lost the deceased alive on 5/19/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.	
54. SIGNATURE		55. DEGREE		56. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		57. DATE SIGNED		58. 6/15/87	
59. PHYSICIAN'S NAME (TYPE OR PRINT)		60. ADDRESS		61. CHESTERTOWN, Md		62. 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
C.G. Baum						Burial		06-13-87	
63. NAME OF CEMETERY OR CREMATORY		64. LOCATION CITY OR TOWN COUNTY STATE		65. 24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Church Hill Cemetery		Church Hill Q.A. MD		Tom Helfenbein Funeral Home, Church Hill, MD 21623		JUN 18 1987		Julia Dwyer-Randall	

20% COTTON 20% COTTON

056841

JUN 11

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7

REG. NO.

1 7 5 7 6

1. DECEASED NAME (TYPE OR PRINT) Katherine L. Wetsell			2a. DATE OF DEATH MONTH DAY YEAR 6 5 87		2b. HOUR P 8:10 M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Apr 8, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Annes Hospital, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Upholsterer		12b. KIND OF BUSINESS OR INDUSTRY Upholstering
13a. STATE Maryland			13b. CITY OR TOWN Queen Anne's Barclay		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John Lucas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Wasko		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216052105A		17. INFORMANT ADDRESS Cecil Wetsell, Barclay, MD 21668	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AS CVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 hr.
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Michael P. Bey</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6/5/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael P. Bey		22e. ADDRESS Millington Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/10/87	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery Hillsboro	23d. LOCATION CITY OR TOWN COUNTY STATE Caroline MD
24. FUNERAL DIRECTOR NAME Randolph P. Moore		25a. DATE REC'D. BY REGISTRAR JUN 11 1987	25b. REGISTRAR'S SIGNATURE Julia Swenson-Randee

SECTION FIFTH

No

2102200A Geol Water, 10, 20, 30

John, James, Susan, Anne

1000 1000 1000 1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) Pearl Hazel Williams											
2a. DATE OF DEATH MONTH DAY YEAR 6- 14- 87											
2b. HOUR P 3:30 M											
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Feb 23, 1914			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.		
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.P.N. (Hospital Nurse)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Kent			13c. CITY OR TOWN Chestertown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Walter Meekins			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Miller			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218 30 2227		
17. INFORMANT ADDRESS RFD Fairlee			18. MARY JONES ANTHONY CHESTERTOWN, MD. 21620			19. STREET ADDRESS / ZIP CODE RFD Fairlee 21620			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) C & PD + BRONCHIECTASIS DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HYPERTENSIVE CARDIOVASCULAR DISEASE, THORACIC ANEURYSM											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION STREET CITY OR TOWN COUNTY STATE		
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21f. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21g. LOCATION STREET CITY OR TOWN COUNTY STATE			21h. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I the hospital) attended the deceased from 4 DEC 1970 to 6-14 1987 , that (I was lost saw the deceased alive on 6-14 1987 , and that in (my) best opinion death occurred on the date and hour and from the causes stated above, (I was did) not view the body after death.											
22b. SIGNATURE Harry Paul Ross			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6-17-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Paul Ross			22e. ADDRESS Chestertown, Md. 21620			23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 6/17/87		
23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md			24. FUNERAL DIRECTOR NAME J. Willis Wells			25. DATE REC'D. BY REGISTRAR JUN 19 1987		
25a. REGISTRAR'S SIGNATURE Julia Darden-Randall			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE			25d. REGISTRAR'S SIGNATURE		

BP

